

MDR Tracking Number: M5-04-0213-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 09-17-03.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did prevail** on the issues of medical necessity. The IRO disagrees with the previous determination that the Hydrocodone and Bextra for date of service 08-12-03 were not medically necessary.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 12-31-03, the Medical Review Division submitted a Notice to the requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The requestor failed to submit proof of "written notices of adverse determinations (both initial and reconsideration)" from the insurance carrier or "convincing evidence of carrier receipt" of the request for reimbursement of out of pocket expenses for date of service 09-12-03 per Rule 133.308(f)(2)(3). No reimbursement is recommended for date of service 09-12-03.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 08-12-03 and 09-12-03 in this dispute.

This Findings and Decision and Order are hereby issued this 15th day of April 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION amended

December 19, 2003

Re: IRO Case # M5-04-0213-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient developed pain in his mid-back region secondary to an injury in _____. He was diagnosed with thoracic disk rupture on MRI. Discography suggested this to be the source of the patient's discomfort. The patient has had multiple injections, blocks, rhizotomy and spinal cord stimulation. He continues to work with the help of the medications in dispute. Surgery was recommended at one point and another opinion was going to be obtained. No record was provided for this review of that opinion or any subsequent discussion of surgery.

Requested Service(s)

RX Bextra and Hydrocodone 8/12/03

Decision

I disagree with the carrier's decision to deny the requested medication.

Rational

The anti inflammatory effects of the medications in combination is often beneficial enough to allow a patient to perform the usual tasks for reasonable living, including work. It has been well-documented that the patient has anatomical changes that are frequently compatible with chronic pain, and are frequently not relieved by any particular operative procedure or injection, except to the extent that those procedures plus medication often make the pain tolerable.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.